

EXHIBIT D



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS NORTHEAST COVERAGES 152 MINEOLA BLVD Mineola, NY, 11501		COMPANY: NorGUARD Insurance Company	
PRODUCER NAME: 516-543-0411		UNDERWRITER:	
CS REPRESENTATIVE NAME:		APPLICANT NAME: TD CONSTRUCTION SERVICES CORP	
OFFICE PHONE (A/C, No, Ext):		OFFICE PHONE:	MOBILE PHONE:
MOBILE PHONE:		MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code) 63 FLUSHING AVE UNIT 346 BROOKLYN NY 11205	
FAX (A/C, No):		YRS IN BUS: 0	
E-MAIL ADDRESS:		SIC:	
CODE: NYRMAI10 SUB CODE:		NAICS:	
AGENCY CUSTOMER ID:		WEBSITE ADDRESS:	
E-MAIL ADDRESS:		SOLE PROPRIETOR <input checked="" type="checkbox"/> CORPORATION <input type="checkbox"/> LLC <input type="checkbox"/> TRUST <input type="checkbox"/>	
CREDIT BUREAU NAME:		PARTNERSHIP <input type="checkbox"/> SUBCHAPTER 'S' CORP <input type="checkbox"/> JOINT VENTURE <input type="checkbox"/> OTHER <input type="checkbox"/>	
FEDERAL EMPLOYER ID NUMBER		NCCI RISK ID NUMBER	ID NUMBER:
OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER			

STATUS OF SUBMISSION		BILLING / AUDIT INFORMATION	
QUOTE <input checked="" type="checkbox"/> ISSUE POLICY	BILLING PLAN	PAYMENT PLAN	AUDIT
BOUND (Give date and/or attach copy)	AGENCY BILL <input type="checkbox"/>	ANNUAL <input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> AT EXPIRATION <input type="checkbox"/> MONTHLY
ASSIGNED RISK (Attach ACORD 133)	DIRECT BILL <input checked="" type="checkbox"/>	SEMI-ANNUAL <input type="checkbox"/>	SEMI-ANNUAL <input type="checkbox"/>
		QUARTERLY <input type="checkbox"/> % DOWN:	QUARTERLY <input type="checkbox"/>

LOCATIONS		
LOC #	HIGHEST FLOOR	STREET, CITY, COUNTY, STATE, ZIP CODE
000		63 FLUSHING AVE, UNIT 346, BROOKLYN, Kings NY 11205
001		63 FLUSHING AVE, UNIT 346, BROOKLYN, Kings NY 11205

POLICY INFORMATION	
PROPOSED EFF DATE 09/28/2012	PROPOSED EXP DATE 09/28/2013
NORMAL ANNIVERSARY RATING DATE	PARTICIPATING <input checked="" type="checkbox"/> NON-PARTICIPATING
RETRO PLAN	
PART 1 - WORKERS COMPENSATION (States) NY	PART 2 - EMPLOYER'S LIABILITY
	\$ 100,000 EACH ACCIDENT
	\$ 500,000 DISEASE-POLICY LIMIT
	\$ 100,000 DISEASE-EACH EMPLOYEE
PART 3 - OTHER STATES INS	DEDUCTIBLES (N / A in WI)
	MEDICAL <input type="checkbox"/>
	INDEMNITY <input type="checkbox"/>
AMOUNT / % (N / A in WI)	0
OTHER COVERAGES	U.S.L. & H. VOLUNTARY COMP <input type="checkbox"/>
	FOREIGN COV <input type="checkbox"/>
	MANAGED CARE OPTION <input type="checkbox"/>
DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)	

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES		
TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES \$9,959 *	TOTAL MINIMUM PREMIUM ALL STATES \$	TOTAL DEPOSIT PREMIUM ALL STATES \$

CONTACT INFORMATION				
TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION	ATHINA ROBINSON	718-360-5057		
ACCTNG RECORD CLAIMS INFO				

INDIVIDUALS INCLUDED / EXCLUDED									
PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL
		ATHINA ROBINSON					E		

PRIOR CARRIER INFORMATION / LOSS HISTORY

AGENCY CUSTOMER ID: _____

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS						LOSS RUN ATTACHED
YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO: none					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING - RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR - TYPE OF WORK, SUB-CONTRACTS; MERCANTILE - MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE - TYPE, LOCATION; FARM - ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

RESIDENTIAL	FLAT	CONCRETE	WORK
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GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	N
2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	N
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	N
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	N
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	N
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	N
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	N
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	N
9. ANY GROUP TRANSPORTATION PROVIDED?	N
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	N
11. ANY SEASONAL EMPLOYEES?	N
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	N

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y / N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	N
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	N
15. ARE ATHLETIC TEAMS SPONSORED?	N
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	N
17. ANY OTHER INSURANCE WITH THIS INSURER?	N
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants - Do not answer this question)	N
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	N
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	N
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	N
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	N
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	N
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	N

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

<p>APPLICABLE IN TENNESSEE AND VERMONT: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.</p> <p>ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)</p> <p>IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.</p> <p>IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.</p> <p>IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.</p>			
APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER